Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NUEVA VIDA BEHAVIORAL HEALTH
5555 FREDERICKSBURG RD STE 102
SAN ANTONIO TX 78229

Respondent Name

OLD REPUBLIC INSURANCE CO

Carrier's Austin Representative Box

Box Number 44

MFDR Tracking Number

M4-12-0523-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Preauthorization was obtained and the determination was based on 'medical necessity'."

Amount in Dispute: $680.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Insurance Carrier, or its agent, did not respond to the request for medical dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 4, 2011	CPT Code 97799-CP	$680.00	$680.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.600 sets out the procedures for preauthorization of certain services/treatments.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated June 17, 2011 and September 27, 2011:
   - 203 – Peer review has determined – payment for treatment has not been recommended due to the lack of medical necessity. Peer review has provided its findings to the provider in prior documentation.
   - 216 – Based on the findings of a review organization.

- W1 – Workers Compensation state fee schedule adjustment.
- 131 – Claim specific negotiated discount.
- 272 – Service reviewed per client instructions.
- 216 – Your documentation of extraordinary circumstances does not justify the use of ML104. The evaluation does not meet the criteria listed in rule 9795(c) ML 104.

Issues

1. Did the Respondent incorrectly deny the service/treatment in accordance with 28 Texas Administrative Code §134.600(c)(1)(B)?
2. Did the requestor obtain preauthorization in accordance with 28 Texas Administrative Code §134.600?
3. Is there a claim specific negotiated discount?
4. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.600(f)(1) the requestor submitted preauthorization approval #: 9NX2Z511-0009 dated April 1, 2001 supporting that they had obtained preauthorization for a chronic pain management program for 10 unites starting March 29, 2011 and ending May 30, 2001.
2. Per 28 Texas Administrative Code §134.600(c)(1)(B) the carrier is liable for all reasonable and necessary medical costs relating to the health care listed in subsection (p) or (q) of this section only when preauthorization of any health care listed in subsection (p) of this section was approved prior to providing the health care.
3. The insurance carrier used denial code "131 – Claim specific negotiated discount"; however, no documentation was submitted by the insurance carrier to support this denial. Therefore, the treatment/service was reviewed in accordance with Texas Workers' Compensation rules and statutes.
4. In accordance with 28 Texas Administrative Code §134.204(h)(1)(B) reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $680.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $680.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 19, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.